First Health Services Corporation
A Coventry Health Care Company

EDI Support

VaMMIS Procedure Manual

Version 1.0

May 5, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	08/2007	Howard Conwell, Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

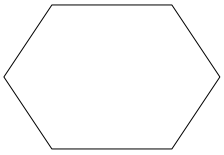
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

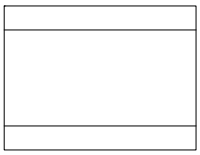
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

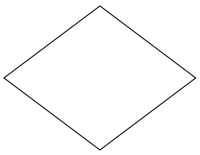


Data Preparation Processing; e.g., mailroom, computer operations, etc.

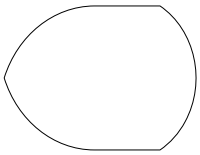


Create a Request

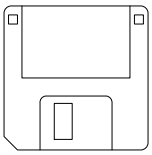
Data maintained in a master datastore.



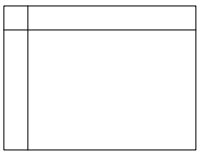
Decision



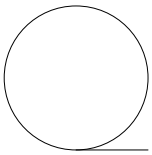
Information entered or displayed on-line.



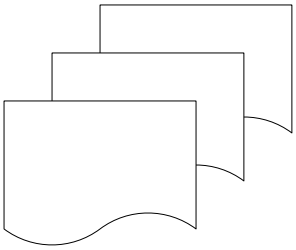
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

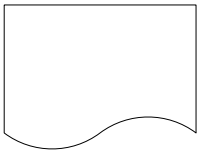


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund.

SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - ❒ Personal Care (implemented 1982)
  - ❒ Adult Day Health Care (implemented 1989)
  - ❒ Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months.

  The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.

- Baby Care Program provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to “spend down” their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the Options program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Approval of EDI Service Centers

Electronic Data Interchange (EDI) submission is the automated process that eliminates manual document preparation, mailing, claims receipt, and data entry of claims into the Virginia MMIS. Upon receipt, EDI transmissions are sent directly to the host system and downloaded to the MMIS on the day of receipt.

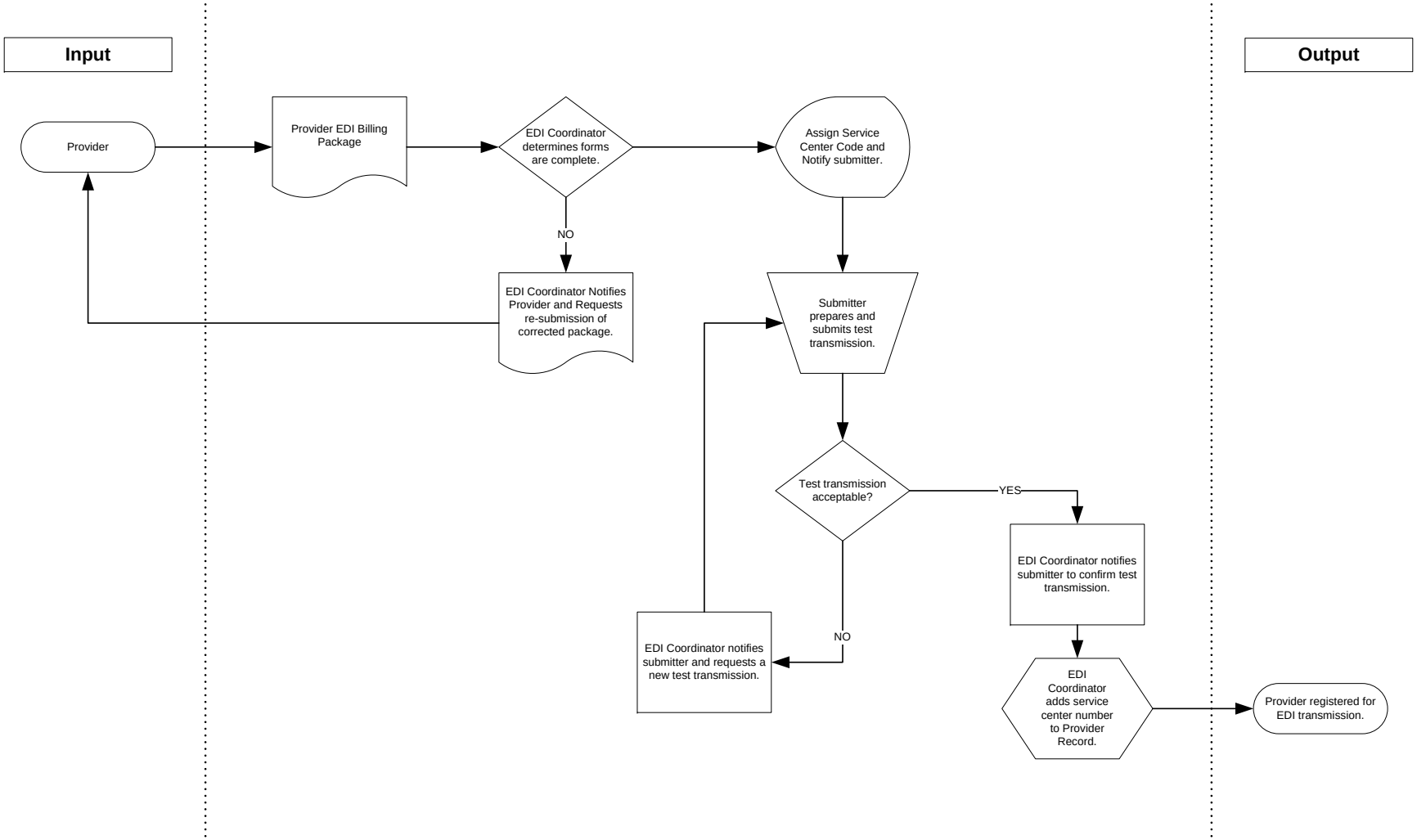
Providers submit Medicaid claims electronically either directly to First Health, or through a clearinghouse. All claim submitters must be registered with First Health as Service Centers, whether a single provider or a clearinghouse, prior to submission of claims to Virginia Medicaid. To register, a provider must submit a forms package, which can be downloaded from the First Health Virginia Medicaid website http://virginia.fhsc.com, to the EDI Co-ordinator at First Health.

The forms package is reviewed by the EDI Coordinator and, if the forms are complete and correct, the provider is assigned a Service Center number and notified of approval as an EDI biller. If the forms package is incomplete or incorrect, the provider is notified of the discrepancy(ies) and requested to resubmit corrected forms.

Once approved, the Service Center can submit a test at any time. If the test is successful, the submitter is notified and the Service Center information is added to the Provider database for input of claims into production. If the test is unsuccessful, the submitter is notified of the errors and requested to send another test.

WORKFLOW PROCESS

EDI Service Center Approval



2.1 Develop and Maintain EDI Billing Procedures

The Provider User Manual for EDI submission contains the information and instructions necessary to submit claims electronically to Virginia Medicaid. This information includes phone numbers, contacts, registration procedures, testing procedures, and copies of the forms to be completed for registration with Virginia Medicaid for electronic submission of claims.

The EDI Coordinator develops the Service Center User Manual for Electronic Transaction submission in conjunction with DMAS. The manual is updated periodically, incorporating information received from electronic claims technicians. Any changes made to the EDI billing procedure are made to this manual, which is maintained and posted on the First Health Virginia Medicaid website http://virginia.fhsc.com.

Note: The Provider User Manual and forms are posted to the Provider Services website in PDF. The forms can be printed out, filled out, signed, and then mailed to the EDI Co-ordinator.

Procedure

1. Modify MS Word document as needed.
2. E-mail the new document to webmaster@fhsc.com who will post the new document to the web site.

2.2 Develop and Maintain EDI Billing Agreements

The EDI Co-ordinator, in conjunction with DMAS, develops the billing agreements that are posted to the First Health Virginia Medicaid website. From this site, the necessary forms can be printed from Adobe Acrobat Reader and filled out. When the forms are completed, the Provider signs it before sending it to the EDI Co-ordinator. If the submitted forms require re-submission, the Provider is notified and requested to re-submit a signed EDI agreement.

The Provider EDI registration package contains the following documents:

- DMAS Electronic Submission of Claims Agreement (Data Service Centers)
- Data Service Center Operational Information
- Electronic Remittance Advice Request with request for these:
  - ❒ Eligibility Request/Response
  - ❒ Claims Status Request/Response
  - ❒ Prior Authorization
  - ❒ Pharmacy Claim (NCPDP – Batch)
  - ❒ Remittance Advice

- ❒ Dental Claim
- ❒ Institutional Claim
- ❒ Professional Claim

Procedure

1. Modify MS Word document as needed.
2. E-mail the new document to webmaster@fhsc.com who will post the new document to the web site.

Note: Samples of the Electronic Remittance Request and Claims agreement follow this page.

2.2.1 Electronic Submission of Claims Agreement Sample

First Health Services Corporation
A Coventry Health Care Company

Submission of Electronic Transactions Agreement for Service Centers

This is to certify that _____ of
(Submitter of Electronic Transactions)

_____, _____, _____ _____ on the
(Street Address) (City) (State) (Zip Code)

_____ day of _____, 20 _____, agrees to the following conditions for the submission of electronic transactions to the Department of Medical Assistance Services.

1. The Service Center agrees to abide by the policies and procedures of the Department of Medical Assistance Services.
2. The Service Center is not to be construed as an agent of the Department of Medical Assistance Services.
3. The Service Center is recognized as an electronic transaction preparation service only, and any agreement of participation between providers and the Department of Medical Assistance Services is not affected by this agreement.
4. The Service Center will promptly notify the Department of Medical Assistance Services of the names of providers either added to the service operation or discontinued from service.
5. The agreement may be terminated on thirty day's written notice by either party.
6. This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

First Health Services Corporation		Service Center	
_____ (Signature of Authorized Agent)		_____ (Signature of Owner or Official)	
_____ (Title of Auth. Agent)	_____ (Date)	_____ (Title of Auth. Agent)	_____ (Date
		_____ (Service Center Number)	

Revision Date: 07/2007

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060

EDI – Form 101

2.2.2 Electronic Remittance Request – Service Center Operational Information

First Health Services Corporation
A Coventry Health Care Company

Service Center Operational Information

Please Type or Print Clearly

Submitter Information			
NAME:			
ADDRESS:	CITY:	STATE:	ZIP:
CONTACT NAME FOR REJECTS:			
PHONE NUMBER:	FAX NUMBER:	EMAIL ADDRESS:	

Electronic Transaction Types Desired (MUST test for each prior to production)

☐ Eligibility Request/Response (270/271)	☐ Remittance Advice (835)
☐ Claims Status Request/Response (276/277)	☐ Dental Claim (837 D)
☐ Prior Authorization Request/Response (278/278)	☐ Institutional Claim (837 I)
☐ Pharmacy Claim (NCPDP – batch)	☐ Professional Claim (837 P)

Software Vendor Information			
SOFTWARE VENDOR:	CONTACT NAME:		
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER:	FAX NUMBER:	EMAIL ADDRESS:	

First Health Services' Use Only!

SERVICE CENTER NUMBER: _____

SERVICE CENTER FILE UPDATED: _____ (Date)

PROVIDER MASTER FILE UPDATED: _____ (Date)

SERVICE CENTER PUT INTO TEST: _____ (Date)

SERVICE CENTER PUT INTO PRODUCTION: _____ (Date)

Revision Date: 07/2007

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060

EDI – Form 102

2.2.3 Electronic Remittance Request – Provider Service Center Authorization

First Health Services Corporation
A Coventry Health Care Company

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

☐ **SERVICE CENTER AUTHORIZATION:**

I certify that I have authorized the following service center(s) to submit electronic transactions to the Department of Medical Assistance Services until such time as I notify First Health Services otherwise:

NAME OF SERVICE CENTER PREPARING ELECTRONIC TRANSMISSION

If Adding a New Service Center or a New Transaction:	
SERVICE CENTER NUMBER:	BEGIN DATE:
ELECTRONIC TRANSACTION TYPES SUBMITTED:	
☐ Eligibility Req/Resp (270/271)	☐ Claims Status Req/Resp (276/277)
☐ Prior Authorization Req/Resp (278/278)	☐ Dental (837 D)
☐ Institutional (837 I)	☐ Professional (837 P)
☐ Pharmacy (NCPDP – batch)	
If Terminating a Service Center or a Transaction:	
SERVICE CENTER NUMBER:	END DATE:
TERMINATED ELECTRONIC TRANSACTION TYPES:	
☐ Eligibility Req/Resp (270/271)	☐ Claims Status Req/Resp (276/277)
☐ Prior Authorization Req/Resp (278/278)	☐ Remittance Advice (835)
☐ Dental (837 D)	☐ Institutional (837 I)
☐ Professional (837 P)	☐ Pharmacy (NCPDP – batch)

Please select A or B for an 835 Electronic Remittance Request:

☐ **A** I desire to have Service Center _____ receive my electronic remittances (835) and I understand that I will continue to receive paper remittances only for 30 days after the electronic remittances start. **Refer to Terms and Conditions on Page 2, Item A.**

☐ **B** I desire to have Service Center _____ receive my electronic remittances (835) and I would like my paper remittances to continue for the period selected below. **Refer to Terms and Conditions on Page 2, Item B.**

Please extend my remittance for:

☐ 60 Days ☐ 90 Days ☐ 120 Days

Revision Date: 07/2007

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060

EDI – Form 103
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PROVIDER SERVICE CENTER AUTHORIZATION:

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

PROVIDER NAME		PROVIDER NUMBER
SIGNATURE	DATE	TELEPHONE NUMBER

TERMS AND CONDITIONS:

A. Electronic Remittance Request (835) and Paper Remittances for 30 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that 30 days after I start getting electronic remittances, all paper remittances will cease.

B. Electronic Remittance Request (835) and Paper Remittances Extended for 60 Days, 90 Days, or 120 Days after Production Approval.

I certify that I have authorized the Service Center identified on Page 1 to receive and process my electronic remittances. Although I can have multiple service centers submitting claims for me, I understand that only one service center can accept and process my electronic remittances and that service center must have prior approval from First Health Services to receive electronic remittances. I am also aware that after I start getting electronic remittances, all paper remittances will cease after the delay I selected on Page 1.

Revision Date: 07/2007

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060

EDI – Form 103
Page 2 of 2

2.3 Evaluate, Approve, and Set Up Service Centers

The EDI Co-ordinator evaluates the forms package received from the submitter. If forms are found to be incomplete or incorrect, the provider is notified and requested to re-submit completed/corrected forms. Once forms are determined to be complete and correct, a Service Center Code is assigned, and the site is added as a Service Center. For simplicity, the Service Center Code also becomes the Login ID on the bulletin board and the Submitter ID inside the claims files submitted to **First Health**.

The provider is then notified, either by mail, telephone or FAX, of their Service Center Code and informed that **First Health** is ready to receive a test file at any time.

Procedure

1. Receive forms package from a provider. Four forms are required for assignment of a Service Center Code:
   - ❖ DMAS Electronic Submission of Claims Agreement
   - ❖ Data Service Center Operational Information.
   - ❖ Electronic Remittance Advice Request
   - ❖ Internet Claim Submission Request

   A Service Center Authorization form is required for each Provider number that will be submitting claims/retrieving Remittance Advice through the Service Center.
2. Evaluate the forms for completeness and correctness.
   - ❖ If any form is incomplete or incorrect, notify the provider, either by mail, telephone or FAX, and request re-submittal of complete and correct form(s).
   - ❖ If all forms are complete and correct, assign the next available Service Center Code from the Service Center List.
3. The Service Center Numbers are maintained in an MS-Excel spreadsheet. Go to the Type of Media field to get the next available number assigned.
4. Enter Service Center information into the MS-Excel spreadsheet. Enter the data listed below:
   - ❖ Service Center Name
   - ❖ Service Center Number
   - ❖ Address
   - ❖ Telephone number
   - ❖ Contact Name

- ❖ Service Center Test Begin Date
- ❖ Service Center Test End Date
- ❖ Service Center Production Begin Date.

5. Notify the provider, either by mail, telephone or FAX, of their Service Center Number and that First Health is ready to receive a test file.

2.4 Test EDI Transmissions

The EDI Coordinator periodically checks to see if any test files have been received. Once aware of file receipt, the file is run through the test adjudication system and the Service Center is notified of the test results. Test results are usually available within 24 to 48 hours, but may take longer because of operational considerations.

Note: A 997 will always be produced for each file received. If there are compliance errors which prevent the file from processing though the EDI mapper, the errors will be listed on the 997. In that case the errors must be corrected and the file sent again. If no errors are listed, this will serve as verification to the sender that the file was compliant, made it through our mapper, and the file was accepted and processed.

A test is considered successful if the following conditions are met:

- No errors causing the entire file to be rejected are encountered (i.e., Provider number is not numeric, etc.)
- Certain required fields are correctly entered (i.e., MEDALLION PCP number in correct field, etc.)
- Any other problem the EDI Co-ordinator is aware of, which has been identified in the past by other Service Centers (it is easier to fix a problem while the Service Center is in Test than after they go into Production).

If the test transmission is successful, the EDI Coordinator e-mails, calls or FAXes the Service Center with the results, and enter the service center information (Service Center Number, Service Center Name, Service Center function (Electronic Claims/Transportation, Electronic Remittance Advice or HMO's (Encounter Data)) in the Provider Service Center screen for 'Production' for the tested electronic media type.

If the test transmission is not successful, the EDI Co-ordinator e-mails, calls or FAXes a report to the Service Center identifying the errors that caused the submission to be disapproved, and requests re-submission.

Procedure

1. Check to see if any test files have been received.

2. If files are available, determine the claim type, Service Center number, and dataset generation number.
3. Submit correct JCL to run file through test adjudication system.
4. After the test is complete, evaluate test results.
    - ❖ If the test was good, e-mail, phone or FAX the Service Center with the test results.
    - ❖ If the test was bad, e-mail, phone or FAX the Service Center an error report and request a re-transmission.
5. Enter the Service Center information (Service Center Number, Service Center Name, Service Center function (Electronic Claims/Transportation, Electronic Remittance Advice or HMOs (Encounter Data)) in the Provider Service Center screen (PS-S-031).

2.5 Add Provider Service Center to Provider Record

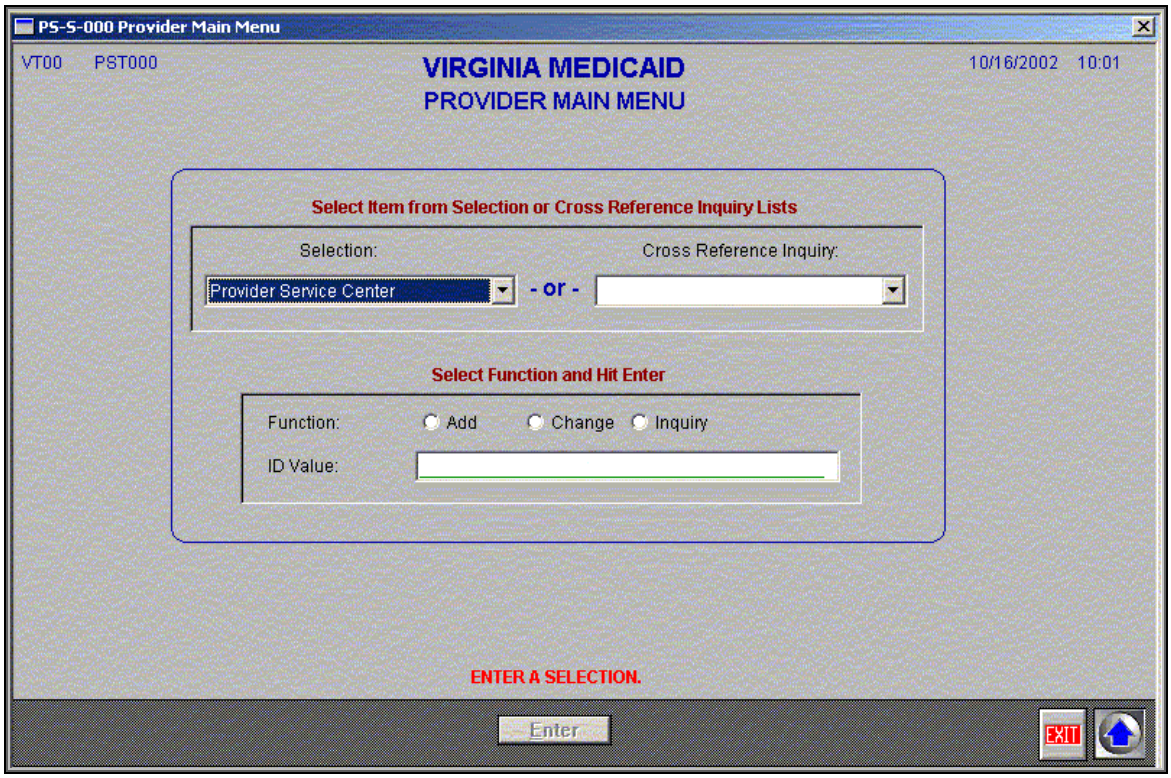
Once the EDI Coordinator has a successful test transmission and has notified the Provider, the Provider Service Center number must be added to the Provider's record. This is done using a special screen in the VaMMIS Provider Subsystem.

Note: In most cases, you will have to add a service center first, before linking a Provider to the service center. The instructions below reflect this sequence.

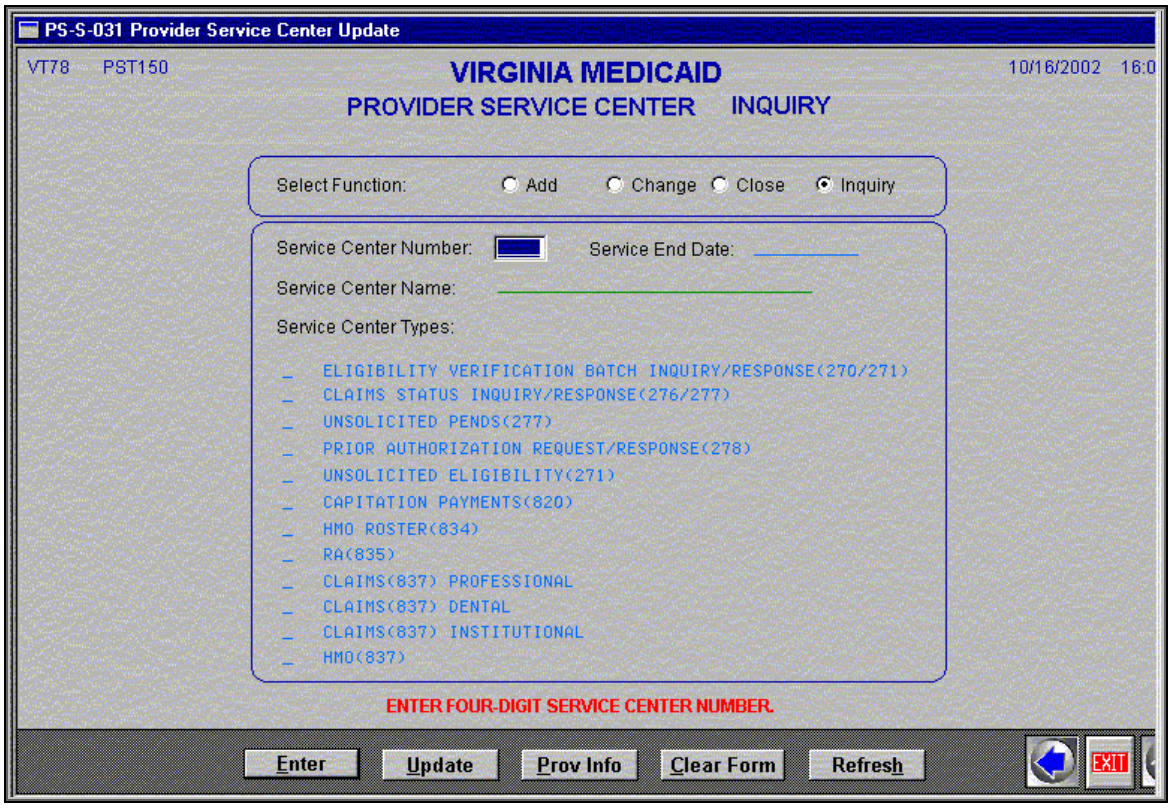
Procedure

To add a service center:

1. Log in to the VaMMIS Main System Menu.
2. Select the **Provider** icon.
3. Choose **Enter**.
4. Start at the **Provider Main Menu**.
5. Select **Service Center Updates** from drop-down menu in the **Selection** field.



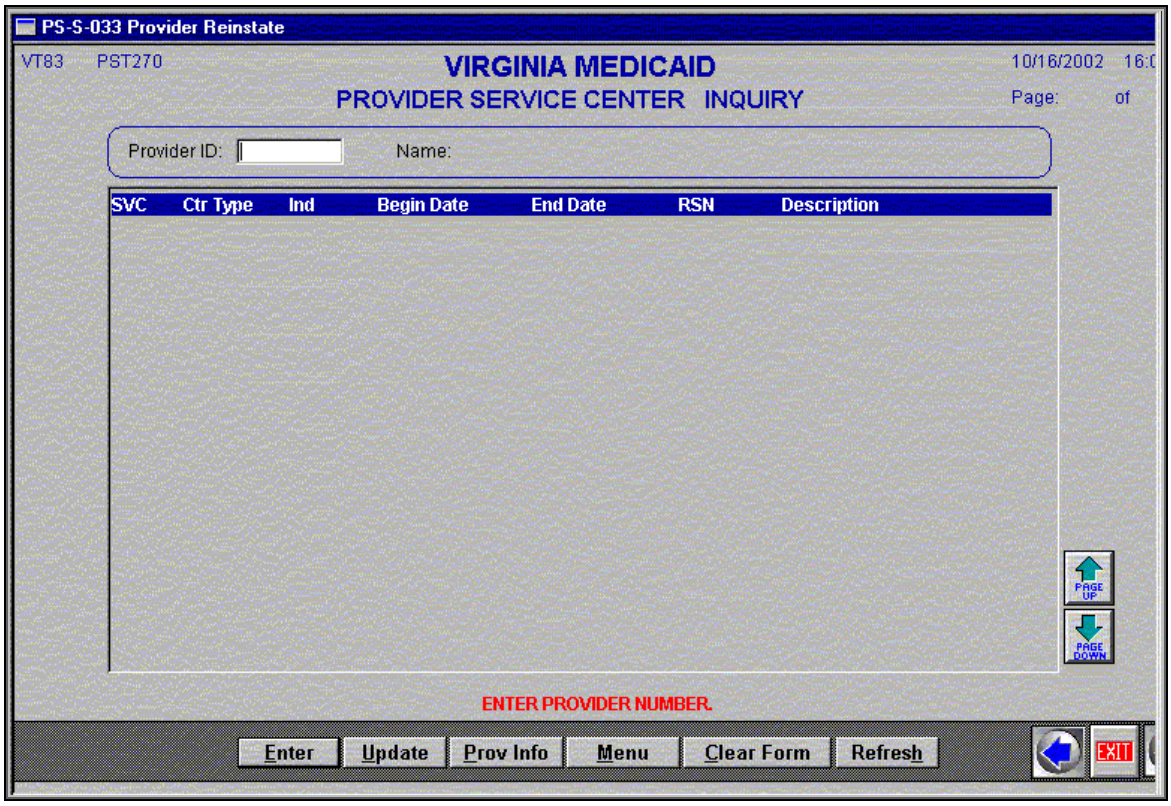
6. Click the **Add** or **Change** radio button in the **Function** field.
7. Enter the Provider Service Center Number in the **ID Value** field.
8. Choose **Enter**.
9. You see the **Service Center Update** screen (PS-S-031).



10. Click a radio button to **Add** or **Update**.
11. Enter a four-digit service center number, if necessary.
12. If an error messages appear, make any required correction(s) and choose **Enter** again.
13. When no error messages appear, choose **Update** save the data.

The Service Center is now added to the Provider Database and the service center information is now added to the provider record.

The Provider may now submit claims electronically. If necessary, choose the **Service Center** button to go to the **Provider Service Center** screen (PS-S-033) to inquire or add additional information about the Provider's use of the Service Center.



2.6 Enter Provider EMC Form Counts into the CPMSystem

The EDI Support group will process Provider EDI applications regularly. As part of the Contract Monitoring System (CMS), the group will keep track of the number of Provider EDI applications received and processed. To do this, a member of the group will use a web input screen that will load this data into the CMS database for retrieval by the CPM reporting tool.

Procedure

1. Open the main On-line HELP page.
2. Choose **EDI Applications** from the navigation bar.
3. You see this log-on screen.

1. Enter your LAN User ID in the **User ID** field.

2. Enter your password.
3. Click the **Login** button.
4. You see the EDI Applications window in list view format (all the data entered to date) displays. Choose the **New** button. You see this window:

5. Enter the number of EDI applications received in the **Total In** field.
6. Enter the number of EDI applications completely processed in the **Total Processed** field.
7. Enter your User ID (same as your LAN log-in name) in the **User ID** field.
8. Choose the **Insert** button when you finish.

If you make a mistake and want to cancel the work you have already entered, choose the **Cancel** button to cancel your work.

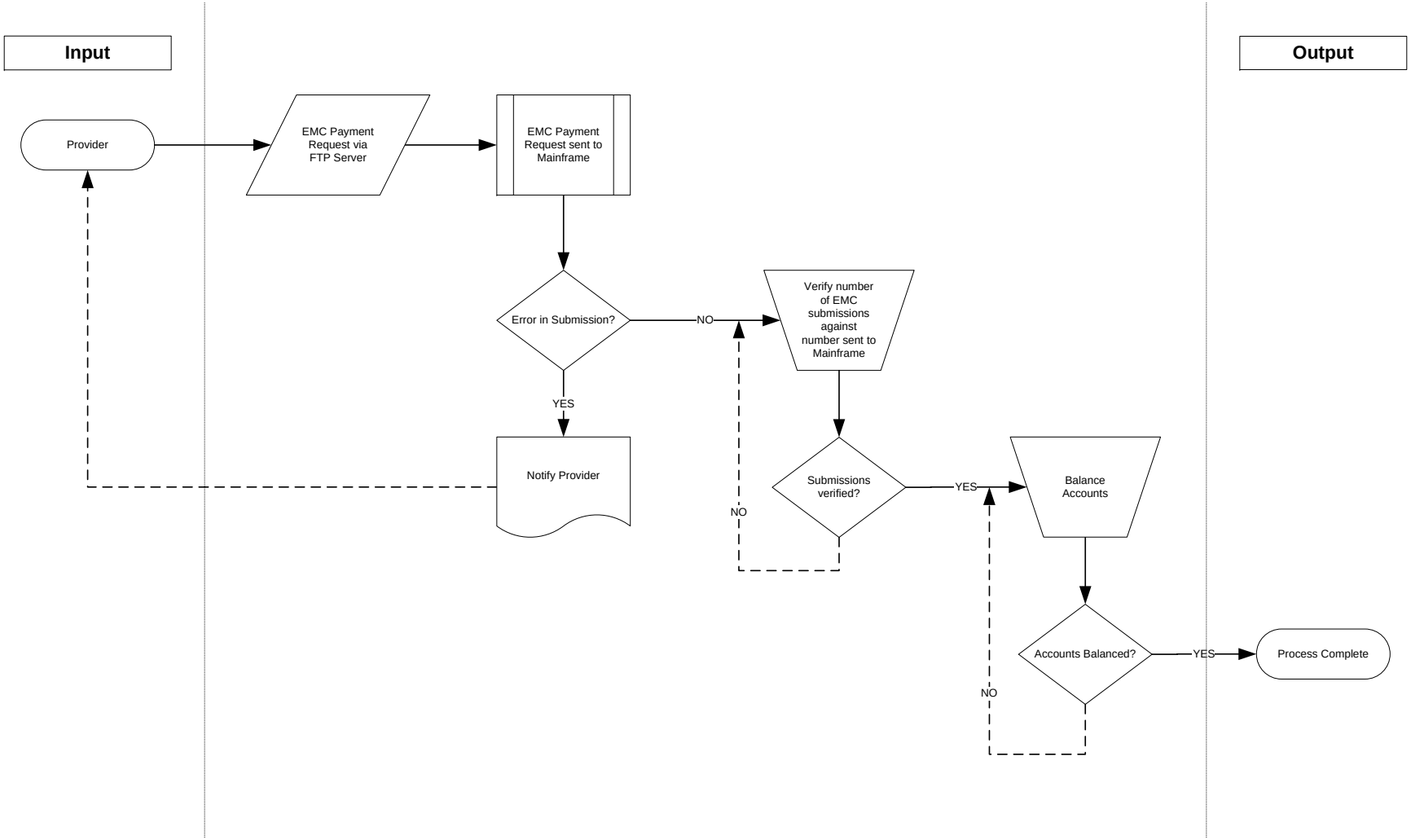
Data you enter here will be used to populate data in the Contract Monitoring System report for requirement 5.6.2.2.e-2.

3.0 Maintain and Control EMC Media

The Electronic Media Claims (EMC) Team receives and controls all EMC claims received via modem. The team is responsible for receiving all claims daily and verifying that the claims have been transferred to the mainframe. The Quality Control department balances the count of claims received daily.

WORKFLOW PROCESS

Maintain and Control EDI Media



3.1 Receive and Process EMC Media

EMC payment requests are only received via Secure Socket Layer (SSL) FTP. The EDI team is responsible for receiving and processing this EDI media. The team ensures that the VMAP FTP Server is up and operational, and receiving file transmissions.

Upon receipt, a file is opened and evaluated by the FTP server software. If the file meets current criteria, it is assigned an MCN number, JCL is written to transmit the file by BARRTRANS via the RJE to the mainframe where it becomes the next generation of a generation data set.

Generation data sets are picked up four times by the VaMMIS and processed throughout the day on a schedule determined by operations.

Procedure

1. Daily, check the VMAP FTP server to ensure that it is on-line and working, and available to receive transmissions.
2. If it is not working, immediately contact Systems Administration.

3.2 Research Requests for EDI Support/Queries

The EDI team receives requests for EDI support from providers, vendors, clearinghouses, and DMAS. All such requests are researched and responded to. This includes errors in transmission and errors in files transferred. The EDI team is available from 8:30 a.m. to 4:00 p.m. daily to respond to any request for support. Requests for support can come in many forms, by letter, e-mail, fax, or phone.

Support includes answering inquiries, assistance with set-up or making corrections, evaluating problems with files containing errors or rejections, evaluating transmission problems, tracking files for which payment has not been received, and test file results.

All requests are researched and responded to in a timely manner.

Procedure

No sequential procedures are used for this task.

3.3 Maintain and Update EDI Media Files

Semi-annually, the EDI team culls the files and terminates inactive providers and out-of-date transmission information.

Semi-annually, Information Update Forms are sent to all Service Centers. This form is used to update contact names, phone numbers, and other information. Information on the returned forms is incorporated into the Service Center list.

The EDI team will also evaluate the RAMGR file to determine if the Service Centers are still sending claims. If a Service Center has not dialed into the bulletin board within a certain time frame (usually one year), every effort is made to contact them to find out why, for example:

- Has the person who was sending the claims left, leaving no one else who knows how to file claims?
- Can we get them back up electronically?
- Is another service center being used to send claims?
- Is the provider not going to utilize electronic submission of claims anymore?

If they are no longer using the Service Center number, delete the number, making it available for reassignment to another Provider.

Procedure

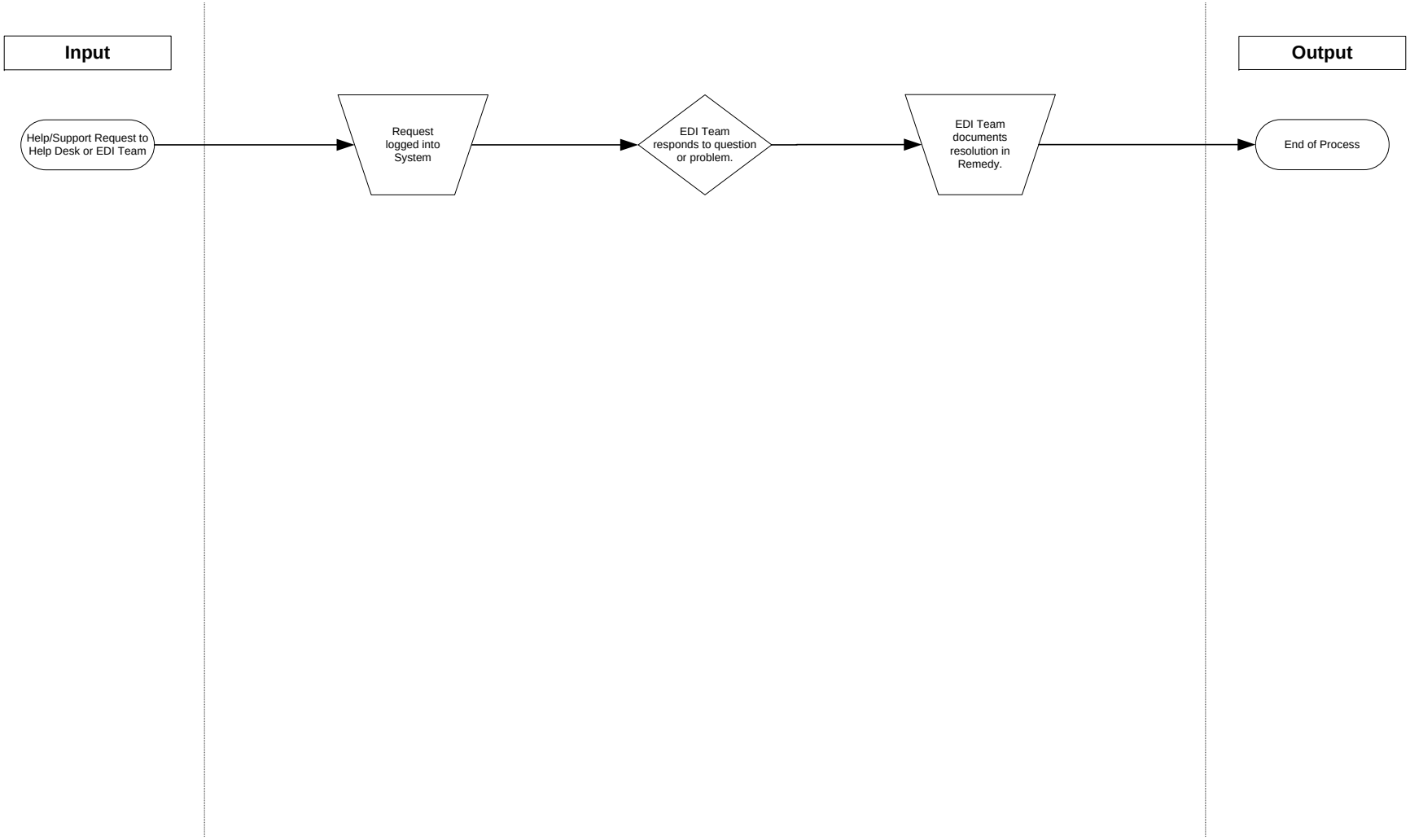
No sequential procedures are used for this task.

4.0 Maintain Help Desk Support

The EDI Team responds to Help Desk inquiries referred to them by DMAS. This includes logging in calls, talking to providers or billers, resolving issues, and documenting the resolution. Additionally, the EDI team maintains the services that allow the provider to submit EMC claims.

WORKFLOW PROCESS

Maintain Help Desk Support



4.1 Receive and Log Help Desk Requests

The EDI team responds to Help Desk requests for information and technical assistance that are specific to operation and usage of the EMC processing system. Most requests are directed to the DMAS Help Desk, and then routed to the EDI Team as necessary. The EDI Team logs in the request for service or information at the time of receipt.

Procedure

No specific procedures for call tracking/logging are included in this manual.

4.2 Document Help Desk Request Resolution

The EDI Team researches provider requests for help and information as quickly and comprehensively as possible, solving problems via the telephone, whenever practicable. The team also documents resolution(s) to assist in faster and easier response should the problem arise again in the future.

Resolution to all provider requests for assistance are logged and tracked using the EDI Teams call/resolution logs.

4.3 Maintain FTP Server Services

The EDI team maintains the information and procedures used by the FTP server. This is limited to the information and daily procedures needed to keep the service viable.

Procedure

No detailed procedures are included for this task.